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Governor Announces His Proposed Budget for FY 2013-2014

Governor Corbett issued his proposed budget for the next fiscal year on February 4, 2014. Highlights of the proposed budget related to Medicaid* and Home and Community-Based Services Waiver programs appear below. The Pennsylvania House and Senate Appropriations Committees have already held hearings on the budget with heads of the various State agencies. In upcoming months, each chamber will develop an appropriations bill detailing spending that will be introduced and debated. Pennsylvania state law requires that a budget be in place by the beginning of the state fiscal year on July 1st. As the deadline approaches, legislative leaders and the governor negotiate a budget that will secure enough votes to pass both chambers.

* In Pennsylvania, our Medicaid program is called Medical Assistance (MA). Throughout the newsletter, we use the general term Medicaid. When referring specifically to Pennsylvania, Medicaid will mean Medical Assistance.

Highlights of the Medicaid Budget

The Governor's budget focuses heavily on his proposed Healthy PA initiative, which would expand health care coverage to approximately half a million uninsured adults but would also make significant changes to current Medicaid eligibility and benefits. Healthy PA requires federal approval to be implemented—see page 5 for more information about Healthy PA.

The Governor proposes a budget of $29.419 billion for FY 2014-15, an increase of $927 million (3.3 percent) over the current fiscal year. It would increase expenditures for the Department of Public Welfare

(DPW) from $11 billion to $11.44 billion, an increase of 3.9 percent. Medicaid spending is set at $8.8 billion, representing 77 percent of the DPW budget.

The proposed budget includes over $2 billion in new federal funds tied to Healthy PA's coverage expansion, which is estimated to cover 605,000 newly-eligible adults in FY 2014-15. The Corbett Administration proposes using Medicaid funding to enroll these individuals into private health insurance plans instead of into the traditional Medicaid delivery system. The budget also projects $125 million in savings related to Healthy PA's proposed program reforms, which would occur starting in January 2015, pending federal approval. These savings would result from:

- **Eliminating General Assistance (GA)-related Medical Assistance** (MA)-- The GA-related MA program is funded only with state dollars. The vast majority of the Healthy PA savings ($108.1 million) are tied to the transfer of GA-related MA recipients to the new Private Coverage Option expansion group that would be fully funded by the federal government until 2017.
- **Eliminating MAWD** -- Eliminating the Medical Assistance for Workers with Disabilities (MAWD) program in January 2015 is projected to generate $7.2 million in savings. Current MAWD recipients with income under 133 percent FPL would be transferred to the new Private Coverage Option; MAWD recipients over 133 percent FPL would be encouraged to apply for coverage and subsidies through the federal Marketplace at HealthCare.gov. MAWD recipients with other Minimal Essential Coverage—such as Medicare—will not qualify for Premium Tax Credits and Cost-Sharing Subsidies through the Marketplace.
- **Benefit Package Reform** – The benefit reforms proposed by Healthy PA are projected to generate $9.5 million in savings. These benefit changes, which introduce a host of new service limits and dollar amount caps, would affect adults on Medicaid, including pregnant women, individuals with disabilities, and seniors. Like the eligibility changes discussed above, these benefits changes are part of the Healthy PA Waiver application and subject to federal approval.

Other initiatives included in the proposed Medicaid budget include:

- **Managed Care Payment Delay** – the budget projects $394 million in savings from delaying payment to the Medicaid physical and behavioral health managed care plans by one month. This one-time only funding mechanism is not expected to impact Medicaid consumers.
- **Primary Care Payments** – the budget does not continue the increased payments to Medicaid primary care providers that was initiated and funded in calendar years 2013 and 2014 by the Affordable Care Act.

Highlights of the Office of Developmental Programs (ODP) Proposed Budget

ODP administers and oversees programs that provide services to individuals with intellectual disabilities (ID) and Autism throughout Pennsylvania. There is no Cost-of-Living Adjustment (COLA) for base funded services (a wide range of services for individuals with ID provided at the county level) under this proposed budget.

Waiver Programs for People With Intellectual Disabilities: The proposed budget for services through the Person-Family Directed Supports (PFDS) Waiver and the Consolidated Waiver includes no COLA for providers, although a general increase in rates for most residential providers is anticipated based on prior costs.

The proposed budget for these Waivers includes funding to:

- Move 29 people from base funding to Waiver.
- Transfer 50 people from State Centers to group homes or life sharing homes under the Consolidated Waiver. Funding for the additional slots would come from $2.5 million in additional state funds plus additional federal Medicaid match under the Money Follows the Person program.
- Provide "day program services" (typically through the PFDS Waiver) to 700 youth identified as having intellectual disabilities aging out of special education in 2014 (typically at the end of the school term in which the student turned 21). An additional $10.5 million in state funds is requested but this would only be sufficient to cover nine months of services. ODP's expectation is that most youth would not start receiving services until October 2014.
- Put 400 individuals currently on the emergency waiting list onto Waivers starting in December of 2014. Funding for the 400 additional Consolidated & PFDS Waiver slots would come from an additional $29.2 million in state funds. An additional $42 million in federal Medicaid matching funds anticipated from the State Balancing Incentive Program (see article on p. 11) would also fund these slots as well as the 700 PFDS slots for youth aging out of special education.
- Increase Waiver services- except for prevocational, respite and transportation services which receive decreased funding in the proposed budget.

Autism Waiver: The proposed ODP budget includes funding to add 100 individuals to the Adult Autism Waiver. Funding would come from an additional $1.1 million in state funds plus an additional $366,000 in federal Medicaid matching funds anticipated from the State Balancing Incentive Program (see page 11). With that increase, and the slots remaining from the increase in FY 13-14, the Adult Autism Waiver could serve a total of 471 individuals.

Highlights of the Office of Long-Term Living (OLTL) Proposed Budget

OLTL administers and oversees programs to support older adults and people with physical disabilities to help them continue to live as independently as possible. Highlights of the proposed OLTL budget include:

- **Aging Waiver**: Increased funding to serve an additional 1,754 older adults through the Aging Waiver. Funding would come from an additional $11.6 million in state funding plus $12.2 million in increased federal Medicaid matching funds from the State Balancing Initiative (see article on p. 11). The Governor's Budget also projects an additional $130 million in Lottery funds available for the Aging Waiver and presumes $3.2 million in savings from "high cost case reviews" of Waiver service plans.
- **Independence, OBRA & COMMCARE Waivers**: Increased funding to serve an additional 1,203 individuals through one of these three Waivers. Funding would come from an additional $12.5 million in state funds plus $10.8 million in increased federal Medicaid matching funds from the State Balancing Initiative (see article on p. 11). OLTL also anticipates saving $583,000 in state funds from a prior authorization process for durable medical equipment, physical therapy, occupational therapy and speech therapy under these Waivers while another portion of the Budget mentions removing coverage of durable medical equipment entirely from these Waivers.
- **Attendant Care Waiver**: Increased funding to serve an additional 396 individuals through the Attendant Care Waiver. Funding would come from an additional $1.3 million in state funds plus $3.9 million in increased federal Medicaid matching funds from the State Balancing Initiative (see page 11).
- **Act 150**: The proposed budget does not include funding to increase the number of persons served by this program. The rationale provided by the Administration is that there is no federal match available for

this state program so additional funding must be used for those programs that will draw down federal matching funds such as the Waiver programs listed above. Unfortunately, because Act 150 serves individuals with disabilities whose income is over the Waiver limits, often due to their employment, the state's decision not to add more slots for this program will limit the number of working people with disabilities who can obtain home and community based supports.

Note: The Office of Mental Health and Substance Abuse Services (OMHSAS) will hold a budget briefing meeting on March 10th. We will provide details in our March newsletter about the proposed budget for OMHSAS.

Positive Response Received from CMS on Dispute Over Behavioral Health Contracts

Early last summer, the Centers for Medicare & Medicaid Services (CMS) raised questions to the Department of Public Welfare (DPW) about the procurement process used for Medicaid behavioral health services. Since the inception of HealthChoices (mandatory managed care for individuals on Medicaid), Pennsylvania has given a "right of first opportunity" to county mental health offices to hold the contract for behavioral health services for their Medicaid beneficiaries. This means the county offices are given the option to open up for bid and to contract directly with a behavioral health managed care plan or to defer to DPW to bid the contracts. Currently, 44 of Pennsylvania's 67 counties have chosen to hold the contract with a behavioral health managed care plan.

CMS's recent challenge to the procurement process surprised DPW as this issue had previously been raised by CMS and resolved in 2011. In addition, CMS had already approved DPW's statewide HealthChoices Waiver in December 2012 which explicitly states that the Department offers the counties the right of first opportunity in the Behavioral Health-HealthChoices Program.

Essentially, CMS was challenging DPW's arrangement with the 44 counties who contract directly with a behavioral health plan stating the "right of first opportunity" was not allowing an open bidding process. After extensive research and frequent correspondence between CMS and DPW, and much anxiety in the behavioral health stakeholder community, this latest issue has now been resolved. DPW convinced CMS that the contracting process between the state and the counties was, in fact, correctly procured based on federal rules. DPW Deputy Secretary Marion issued a Memo dated February 7th to the Medical Assistance Advisory Committee and to OMHSAS Stakeholders, announcing that DPW received a positive response from CMS regarding its procurement process for the Behavioral Health-HealthChoices Program. Secretary Marion's memo noted that "this is a major step toward CMS approval of the outstanding contracts and rates that have been under review".

State Submits Healthy PA Application for Federal Approval

On February 19, 2014, Governor Corbett officially submitted his Healthy PA application to Secretary Sebelius at the U.S. Department of Health and Human Services. The Centers for Medicare & Medicaid (CMS) has certified the application as complete, and we are now in a public comment period to the federal government that ends March 28th at 4pm. After the federal comment period closes, CMS will review the application and comments and either approve the application as is or request modifications from the state.

To remind readers, the Governor announced last year that Pennsylvania would seek federal permission to implement Healthy PA, an alternative to Medicaid expansion under the Affordable Care Act (ACA). Because the plan is very different from the traditional expansion of Medicaid spelled out in the ACA, the state must apply for and receive an 1115 Waiver from CMS.

On December 6, 2013, the Department of Public Welfare (DPW) released a draft of its Waiver request that detailed the proposal to expand health care coverage and make significant changes to Pennsylvania's existing Medicaid program. PHLP reported on the draft proposal in our January newsletter. During the draft proposal's state comment period, DPW received over 1,000 comments and made some changes in response to these comments. Below is a brief summary of the final Healthy PA application.

Eligibility

Under Healthy PA, Pennsylvania will extend health care coverage to adults age 21 through 64 with income up to 133 percent of the federal poverty level (FPL) who do not currently qualify for Medicaid. Rather than simply enrolling these individuals into the existing Medicaid program, the state intends to use Medicaid dollars to purchase them coverage through a Private Coverage Option (PCO). The exception to this is if someone is determined medically frail—these individuals would be enrolled in Medicaid rather than the PCO. Consumers in the PCO would not have the same benefits and rights as those in Medicaid, including the right to notice and a fair hearing to contest an insurer's denial of covered services.

If approved, Healthy PA will eliminate Medical Assistance for Workers with Disabilities (MAWD) as well as General Assistance Medical Assistance. Individuals in those programs who have income less than 133 percent FPL will be covered under the Private Coverage Option unless determined medically frail in which case they would remain in Medicaid.

Anyone eligible for the new Private Coverage Option will not have the option of getting retroactive coverage when they apply as many applicants for Medicaid currently have. The application clarifies that those eligible for the PCO under the new expansion group will have the ability to get Presumptive Eligibility Medicaid if they are found eligible by a qualified hospital. Like all people getting Presumptive Eligibility Medicaid, these consumers will receive fee-for-service Medicaid until they are found eligible for ongoing coverage through either a Medicaid managed care plan (if medically frail) or the PCO.

Premiums and Work Search Requirement

The Healthy PA application responds, in part, to comments critical of Medicaid premiums and work search requirements. DPW now proposes that, in the first year of the demonstration (starting January 2015), current Medicaid co-pays will remain in place. Individuals on Medicaid and the PCO will not have

premiums during that year but will pay co-pays for certain services. In addition, the application now states, that in year one, providers will be allowed to deny services to persons with income over 100 percent FPL if they do not pay their co-pay.

Beginning in year two, monthly premiums will be charged to adults over 100 percent FPL. That premium will be $25 per month for households with one adult and $35 per month for households with more than one adult. Adults with incomes under 100 percent FPL will continue to have co-payments but these will be paid **to DPW** at the end of the month rather than to the provider and will be capped at 5 percent of their income. Incentives for healthy behavior or work hours will be determined and finalized based on data collected from year one; these incentives will allow individuals who meet certain requirements to reduce their premiums during year two and beyond.

The draft proposal included a far reaching work requirement that requires most adults on Medicaid, except for those in a few exempt groups, to work at least twenty hours per week or to register and participate in job search activities through Pennsylvania's JobGateway program. The final application made few changes to this requirement, aside from renaming it "Encouraging Employment". The application does state that the work search requirement will not be actively enforced during the first year of the demonstration. However, eligibility in year two is dependent on participation in work search activities during year one.

Changes to Benefits

DPW also changed its final application in response to comments about proposed Medicaid benefit limits. The limits will be imposed on all adults over the age of 21 who are receiving MA. While the eligibility, work search, and cost sharing aspects of Healthy PA do not affect seniors on MA who are 65 and older, **the benefit limits will apply to this group**.

The new benefit packages divide consumers into two categories of coverage: low risk and high risk. Some groups, including pregnant women, SSI beneficiaries, individuals dually eligible for Medicare and Medicaid, residents of nursing homes, and individuals receiving Home and Community-Based Services Waivers, will be automatically put into the high risk benefit package. All others will be screened based on a self-administered health assessment or through their claims history to determine if they are eligible for the high risk or the low risk benefit package.

Healthy PA places new limits on nearly every category of Medicaid services. DPW changed the radiology limits from a monetary amount (i.e., up to $750) to more understandable figures allowing those in the low risk category to have six tests per year and high risk individuals to have eight tests. DPW also increased coverage for durable medical equipment and medical supplies from a combined maximum of $2,500 to a $2,500 limit on DME **and** a separate $2,500 limit for supplies for the high-risk group (the limits for the low-risk group are $1,000 in each category).

In response to continuing criticism that these new limits on Medicaid beneficiaries will harm the individuals who need medically necessary treatment and services above these limits, DPW states that its benefit limit exception process is sufficient. In the section of the final application addressing comments received, the state announced it intends to make parts of the process automatic to ease the administrative burdens benefit limit exceptions will create; however, the application provided no further details about this.

The Healthy PA application states that Medicaid will no longer cover podiatry, optometry, and chiropractic services for adults.

The Governor's Healthy PA initiative has dramatic implications on the existing Medicaid program and for extending health care coverage to adults age 21-64 with limited incomes and no other insurance. Readers can view the Healthy PA application in its entirety here. Individuals can submit comments to the federal government until March 28th here.

Pennsylvania Creates a Long-Term Care Commission

On January 31, 2014, Governor Tom Corbett signed an Executive Order establishing the Pennsylvania Long-Term Care Commission. The Commission will study ways to improve the long-term care system in Pennsylvania, including identifying effective ways to provide a better coordinated approach to delivering services and supports and ensuring quality health care for older Pennsylvanians and individuals with disabilities.

Other responsibilities of the Commission include: identifying and examining critical issues and trends in Pennsylvania's long-term care services and supports delivery system; consulting with the Department of Aging, Office of the Budget, Department of Health, Department of Insurance, and Department of Public Welfare on matters related to long-term care; reviewing current and proposed state and federal legislation and regulations related to long-term care; and making written recommendations to Governor Corbett on its findings.

The creation of the Commission is part of an effort begun in July 2013 when the Secretary of the Department of Public Welfare, Beverly Mackereth, announced in a letter to legislative leaders that the Department intended to form two workgroups to explore models of care for the dual eligible population and the delivery of long-term care in Pennsylvania. In her letter, Secretary Mackereth highlighted concerns about the high costs of providing long-term care in Pennsylvania, the growing demand for services as Pennsylvania's population ages, and the fragmented long-term care system which results in confusion among consumers and difficulty accessing care and services. At this time, there will not be a separate group formed to study dual eligible models of care.

The Governor named 25 members to the Commission. These members come from across the state and include representatives from various stakeholder groups including: consumers, agencies serving individuals with disabilities, local Area Agencies on Aging, legislators, managed care organizations, long-term care and other health care providers, and the medical community. The Commission is co-chaired by Secretary Mackereth and Secretary of Aging Brian Duke. The Commission's first meeting is scheduled for March 7, 2014 and it has until December 31, 2014 to complete its study and submit its findings to the Governor.

2014 Federal Poverty Levels Announced

The 2014 federal poverty level (FPL) guidelines were issued in January. Public benefit programs (such as Medicaid) use these guidelines to determine who qualifies for coverage. Click here for a chart showing the 2014 income and resource limits for many Medicaid programs as well as CHIP.

The Federally Facilitated Marketplace will continue to use 2013 Federal Poverty Levels when determining individual's eligibility for Premium Tax Credits (100 - 400 percent FPL) and Cost-Sharing Reduction Subsidies (< 250 percent FPL). The Marketplace will only begin using the 2014 income limits when Open Enrollment for 2015 begins later this year.

DPW Clarifies Policy Regarding Medicaid Managed Care In-person Grievances and Complaints

As Pennsylvania expanded Medicaid managed care (hereinafter "HealthChoices") for physical health care throughout the state, one issue that arose was how in-person grievances and complaints were being handled by the HealthChoices plans. Longstanding HealthChoices rules specify that plan members filing a complaint or grievance with their plan have a right to participate in the complaint or grievance in person, by phone, or by videoconference (if available). Neither the Physical Health-HealthChoices Request For Proposal, nor the state's contracts with the plans, spelled out how in-person proceedings were to occur when the health plans were now doing business in HealthChoices Zones far away from their main offices.

PHLP was contacted by consumers in the HealthChoices New West and the New East Zones who reported problems when they requested an in-person proceeding with their plan. Some individuals were told they needed to come to the plan's main offices (which were located outside of the HealthChoices Zone) for in-person proceedings. Others were given a location within the Zone but when they arrived for their "in-person proceeding" they were surprised to find that none of the members of the plan's review panel were physically present but instead all were attending by phone!

PHLP and the Consumer Subcommittee of the state's Medical Assistance Advisory Committee raised these issues to DPW— arguing it is unreasonable for the plans to require consumers to travel great distances outside of their HealthChoices Zone to exercise their right to an in-person complaint or grievance and that a consumer's right to an "in-person" proceeding is not being honored if they are not face to face with the review committee. DPW's Office of Medical Assistance Programs agreed with the concerns and promised to address the matter. After a number of meetings with the Consumer Subcommittee and with the plans, DPW issued a Managed Care Operations Memorandum, MCOPS Memo #07/2013, which is now in effect. The Memo accomplishes a number of things:

- It mandates the HealthChoices Physical Health Plans to have at least one location within each Zone in which they operate where they will conduct in-person grievances and complaints.
- It informs the Plans that all review panel members should be physically present for the proceeding and that, at minimum, at least one panel member must be face to face with the consumer.
- It directs that if any members of review panel will not be physical present for the in-person complaint or grievance, the Plan must notify the consumer in writing, or by phone if written notice is not possible, in advance of the proceeding stating which panel members will not be physically present at the meeting and instead be attending by phone or videoconference. The plan must also tell the consumer how to submit any evidence they have prior to the review so that it will be received by all the panel members.
- It requires the Plans to develop protocols and procedures for conducting in-person complaints and grievances at each Zone location that must be submitted to DPW for approval.

PHLP was recently informed by DPW that the Plans' protocols and procedures, as well as the locations they have chosen for in-person complaints and grievances within each Zone, have all been approved DPW and are now in place.

New Law Allows More People to Qualify for PACE and PACENET

On February 7, 2014, Governor Corbett signed House Bill 777 into law. This law went into effect immediately and changes how income is counted for the PACE and PACENET Programs. Historically, when determining an applicant's eligibility, the PACE and PACENET programs considered the applicant's gross income from all sources- including their gross Social Security benefit prior to the payment of their monthly Medicare Part B premium. Now, under the new law, PACE and PACENET will only count the amount of the applicant's Social Security benefit after the Part B premium is paid. The standard Medicare Part B premium is currently $104.90 per month and is typically automatically deducted from the person's Social Security benefit.

The Pharmaceutical Assistance for the Elderly Program (PACE) is a state program (funded through the Pennsylvania Lottery) that pays for medications at the pharmacy for elderly individuals age 65 and older who meet the program's income guidelines. There are actually 2 programs: PACE for those with the lowest income and PACENET for those whose income is slightly higher.

To be eligible for PACE, a single individual must have income less than $14,500/year and a married couple income less than $17,700/year*. Those approved for PACE are able to get their medications from participating pharmacies for small co-pays ($6 for generics; $9 for name brands).

To be eligible for PACENET, a single individual must have income between $14,500 and $23, 500/year and married couples income must be between $17,700 and $31,500/year*. Those approved for PACENET must meet a $35.50 monthly deductible and are then able to get their medications from participating pharmacies for co-pays of $8/generics and $15/name brands.

*When determining eligibility, PACE uses income from the previous year.

Until PACE has new applications made and distributed, they will be assuming that every current member and every new applicant is receiving Medicare Part B and paying for it. As a result, PACE will automatically deduct $1,258/year from the reported Social Security income of a single person and $2,516/year from the Social Security income of a married couple.

In mid-February, PACE started to mail out letters to 11,000 individuals enrolled in PACENET telling them that because their Part B premium would no longer be counted as income, they are now eligible for PACE and are being enrolled in that program. PACE also sent letters out to 8,000 individuals who applied for PACENET over the last year and were determined ineligible for the program based on their income. The letter tells these individuals they were re-evaluated under the new law and have now been determined eligible for PACENET.

Anyone with questions about PACE/PACENET eligibility and about this change in the law can contact PACE/PACENET Cardholder Services at 1-800-225-7223 or PHLP's Helpline at 1-800-274-3258 for assistance.

Marketplace Enrollment Updates

Individuals wishing to enroll in a Qualified Health Plan through the Federally Facilitated Marketplace (FFM) must act by March 31, 2014. This is when the Open Enrollment Period for 2014 coverage ends. The start date of coverage depends on the date of enrollment and when the first month's premium is paid to the plan. Each plan sets the deadline for when the first month's premium must be paid for a specific start date. Generally, individuals that enroll in a plan prior to March 15th, and pay their premium by the plan's deadline, will have coverage starting April 1st. Individuals that enroll after the 15th but before March 31st should have coverage starting May 1st.

After Open Enrollment ends, consumers will only be able to enroll in Marketplace coverage for the remainder of 2014 if they meet certain criteria for a Special Enrollment Period. Circumstances that will allow someone a Special Enrollment Period for the Marketplace include: permanently moving to or from a different state, losing Minimal Essential Coverage (for reasons other than failing to pay a premium), experiencing a life changing event such as having or adopting a child or getting married, or experiencing enrollment errors as a result of problems with the Marketplace. Individuals that miss the March 31st enrollment deadline and who do not qualify for a Special Enrollment Period will have to wait until the 2015 Open Enrollment Period beginning this Fall. As a reminder, adults and children who do not have Minimal Essential Coverage in 2014 and whose income is above 100 percent FPL will be subject to a penalty.

Information for People Who Have Previously Tried to Enroll and Had Problems

Those who previously faced difficulty navigating HealthCare.gov should be persistent. The Obama Administration has reworked many of the glitches people experienced when Open Enrollment started in October 2013 and corrected many problems initially faced by applicants.

In addition to fixing many of the application glitches, the Administration has taken action to resolve other application problems consumers have experienced. Individuals needing help with Marketplace applications and enrollments are encouraged to find sources of local help by visiting localhelp.healthcare.gov or calling the Marketplace at 1-800-318-2596.

One problem that has been fixed is what officials have termed "looping". Until recently, the FFM system was not processing applications for adults with income between 100 to 133 percent FPL and instead flagged them to send to the state's Medicaid office regardless of whether that state was expanding Medicaid. Pennsylvania is not expanding Medicaid at this time and therefore the FFM system has been updated so that Pennsylvanians who apply to the Marketplace with income between 100 to 133 percent FPL will not be flagged as potentially Medicaid eligible. Instead, these individuals should have their eligibility for the Premium Tax Credits and Cost Reduction Subsidies determined by the Marketplace. This is a recent fix, so individuals in this situation are encouraged to reapply to the Marketplace using either the website or calling the Marketplace directly.

Persons who have pending appeals with the Marketplace are being advised by the Centers for Medicare & Medicaid Services to reapply before March 31st through HealthCare.gov. Consumers can now reset any existing application(s) and the website is working better so it is less likely to make mistakes when deter-

mining eligibility for tax credits and subsidies. The new application will not cancel the appeal that has already been filed and that appeal will eventually be processed.

Finally, individuals who are already enrolled in Marketplace coverage but have discovered that coverage is not meeting their needs may be able to switch plans. The Marketplace will allow consumers to switch plans to a limited degree before March 31st. Those wishing to switch plans should call the Marketplace directly at 1-800-318-2596 and ask to speak to a representative.

PHLP recently learned that the FFM has started to transfer files to DPW for individuals who applied to the Marketplace and were either told they qualified for Medicaid or who asked to be reviewed for Medicaid under a disability category. It is not yet clear how well that process is working. PHLP continues to encourage people who think they might qualify for Medicaid to apply directly to the Department of Public Welfare for that benefit. Remember, there is no deadline to apply for Medicaid and individuals can apply by calling the PA Consumer Service Center at 1-866-550-4355 or by applying online at www.compass.state.pa.us.

Pennsylvania Pursuing Enhanced Funding from CMS for Balancing Initiative

A little known provision of the Affordable Care Act called the State Balancing Incentive Program allows states to obtain additional federal Medicaid funds to increase access to Home and Community-Based Services (HCBS) and supports. The Department of Public Welfare (DPW) will be applying to the Centers for Medicare & Medicaid Services (CMS) for those additional federal Medicaid funds and plans to use the additional funds to expand HCBS Waiver slots in Pennsylvania as discussed previously in the article about the Governor's proposed budget. DPW projects it will receive almost $69.5 million in additional federal funds in the coming fiscal year through this program. The state plans to submit its application by April to get federal approval and begin receiving the additional funds effective July 2014. The funds are only available until October 2015.

DPW must submit a workplan to CMS, which specifies how the state will comply with three requirements:

- Establishment of a "No Wrong Door-Single Entry Point" application and enrollment system for home and community based services;
- Conflict-free case management services (meaning entities that do case management cannot also provide other Waiver services); and
- Core standardized assessment instruments (the assessment instruments for all Waivers must include common core data).

PHLP and several other advocacy organizations have developed recommendations that were presented to DPW regarding the three requirements to receive the additional federal funds. We'll continue to update readers on future developments.

Consumers Can Appeal Marketplace Decisions

Individuals who apply for health coverage through HealthCare.gov have a right to appeal Marketplace decisions. An applicant can appeal the following types of decisions by the Marketplace:

- Eligibility to purchase health insurance through the Marketplace;
- Eligibility for, or amount of, Premium Tax Credits or Cost Sharing Reductions; and
- Exemption from the requirement to have health insurance.

In addition, once the Open Enrollment Period ends on March 31st, 2014, individuals will be able to appeal determinations concerning their eligibility for a Special Enrollment Period. A Pennsylvania-specific appeal form is available here. Appeal requests must be filed within 90 days of the decision being appealed and should be mailed to:

Health Insurance Marketplace
465 Industrial Parkway
London, KY 40750-0061

Once the appeal is submitted, a consumer should receive a letter acknowledging that the appeal was received. While their appeal is being considered, the individual may be asked to provide more information or documentation. The Marketplace should first provide an opportunity for "informal resolution" of the appeal and then a phone-based hearing. By law, Marketplace appeals should be decided within 90 days of receipt of the appeal "as administratively feasible." It is unclear at this time whether the Marketplace has the infrastructure or capacity to process the 22,000 appeals it has reportedly received thus far.

Individuals wishing to appeal a Marketplace decision and who need help filing the appeal should contact one of the following Pennsylvania Navigators:

- **Mental Health America**- 1-800-969-6642 or health@mhasp.org for assistance. For more information, visit www.mhasp.org.
- **PA Association of Community Health Centers**- 1-866-761-0626 or pachc@pachc.com. Individuals can also visit www.pachc.com.
- **PA Mental Health Consumers Association**- 1-800-887-6422, or navigator@mhapa.org. Individuals can also visit www.pmhca.org for more information.
- **Resources for Human Development**- 1–855-668-9536 or healthinsurance@rhd.org. For more information, visit www.rhd.org.

PHLP: Helping People in Need Get the Health Care They Deserve

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Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

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